Abilities, Inc.
P.O. Box 84
Fort Atkinson, WI 53538
(920) 563-8554

Consent for Financial Supervision

I, _____ authorize Abilities, Inc. to supervise the personal spending

account for _____.

Name of Representative Payee/POA of Estate:_____

Address: _____

City: _____ State: _____ Zip: _____

I understand that this supervision will allow Abilities, Inc. to receive my personal spending and/or payroll checks. It will also allow Abilities, Inc. the ability to cash these checks, deposit them into an account, and distribute the funds according to my financial and personal needs. I also understand that this obligates me to present Abilities, Inc. with the personal spending money on a quarterly or requested basis.*

**Please note that personal spending is preferred to be received by the 5th of each month. Please address personal spending checks to the individual's name, not to the program name or Abilities, Inc. Please send these checks to P.O. Box 84 Fort Atkinson, WI 53538 c/o Resident Personal Spending. All checks received will be cashed and forwarded into the personal spending account within 5 business days.*

In return for this authorization, Abilities, Inc. agrees to document and maintain receipts for all transactions. Abilities, Inc. agrees to forward copies of the spending ledgers quarterly, or upon request. Lastly, Abilities, Inc. agrees to forward all remaining funds to the Representative Payee within 14 days after discharge.

Abilities, Inc. agrees to follow all guidelines established by The Department of Health Services and will not exceed allowable limits. Any substantiation of misappropriation will be immediately reported to the Bureau of Quality Assurance (BQA).

In addition to this authorization, Abilities, Inc. gives the option whether you would like payments for medical and pharmacy co-payments to be made. Please check the box below for which option you chose.

- ☐ **I do not wish to have any personal spending money managed by Abilities, Inc.**
- ☐ **I would like all medical and pharmacy co-payments to be made by Abilities,**

- ☐ **I will pay all medical and pharmacy co-payments. I will make arrangements for all medical providers to send bills directly to me.**

_____ _____

Guardian of Estate/Representative Payee **Date**